

## Drugs and Alcohol – Whose problem is it anyway? Who cares?

### Summary

Stigma and substance misuse are closely linked. This article looks at what can be done to understand how we can destigmatise substance misuse and comes to an intriguing conclusion: *substance misuse behaviour* is stigmatised correctly, whilst the *substance misusing individual* should have his/her stigma removed to reduce barriers to coming forward for increasingly effective treatment.

Primary health care is ideally placed to offer screening for substance misuse and early intervention. Substance misuse in the workplace is costly in both human and financial terms. Work place testing offers an opportunity to detect such problems and provide appropriate help. However, it is not a panacea and results should be interpreted as part of a wider picture.

The link between communicable diseases and substance misuse can result in an increase in stigma, even affecting national guidance on some treatments. Treatments for drug and alcohol problems are more available than ever and increasingly mainstreamed (eg in Primary Care). Self-help approaches are an established cornerstone and helplines offer accessible advice to the community at large.

Health care education has a particular role in destigmatising substance misusers. The costs of substance misuse to the NHS are enormous, so it makes economic as well as clinical sense to invest in greater emphasis on addressing the issue, during both undergraduate and postgraduate training. Until this happens, health services will help to perpetuate stigma rather than take the lead in reducing it.

- Introduction
- Primary Health Care
- The work place and drug screening
- Communicable diseases
- Treatment
- Medical education
- Conclusion

### Introduction

In many parts of society there is a high level of acceptance of alcohol misuse, for instance in pubs, on Saturday night, leading to a high number of visits to Accident and Emergency Departments. The problem has to go a long way before it is stigmatised. Over the last twenty years drink/driving has become much more unacceptable, but a wide range of other drunken behaviour is still broadly accepted broadly and/or excused. It is important to be clear about who is being stigmatised and at what point in their drinking career

Whilst "alcohol is our favourite drug", other drugs are catching up. Mental health services used to be seen as "Cinderella" services, but drug and alcohol services are her disadvantaged sibling – the one you seldom hear about. Despite overwhelming evidence of biological, psychological and social factors contributing to substance misuse (drugs or alcohol), attitudes symbolise the triumph of the "just" - "just stop!"; "just a matter of willpower/faith"; or "just pull your socks up!". Overstretched services often demand motivation before anything is done; yet the main psychological treatment technique is designed for those with low or fluctuating impetus to receive help.

Until recently, most primary health care services could offer nothing but general help, feeling out of their depth in this area. Many places of work turned a blind eye or tacitly/inadvertently supported people in their substance misuse, despite the eventual damage to employer and employee alike.

Historically, much of the response to substance misuse has surfed waves of public concern: communicable diseases since the 1980s and criminality since the 1990s. These supposed connections are not promising when it comes to destigmatisation. The next big issue might be the need to accept that many people with other mental health problems also misuse drugs or alcohol, and that this forms a complex cocktail of risk factors for them and for those around them.

There is a myth that health services aim to cure people. In that case, most clinics fail abjectly; yet no-one suggests that we should close services for people with diabetes or heart disease. The negative view of substance misuse and the success of its treatment has led to under-investment in services. It is surprising that mental health services in general, and substance misuse services in particular, have undervalued improving quality of life and reducing handicap. However, the emphasis is shifting for mental health and there are compelling arguments to offer treatment for people who misuse drugs and alcohol in order to improve their quality of life.

Minimising the damage caused by substance misuse is legitimate, and, done properly, will do no harm. Using alleviation of the problem as a criterion for success, there is good evidence that treatment works. Despite this encouraging finding, medical education (and that of other disciplines) lags behind. Like other common, serious issues (eg sleep disorders, sexual problems), substance misuse is all but ignored in most UK undergraduate medical curricula. The ramifications of not addressing it touch patients, families, society at large and, not least, health services themselves.

### **Primary Health Care**

UK health policy has placed primary care at centre stage. Increasingly, it shapes the rest of health care. The aphorism that "an alcoholic is someone who drinks more than their doctor" illustrates a socially tolerant attitude to alcohol and denial that misuse can give rise to problems. There is an unwitting collusion between this view and the attitudes formed among the stereotypical rugby playing, heavy drinking, male medical student (albeit most current UK medical students are female).

It is unsurprising that primary care is tolerant of alcohol misuse. This reflects society's general failure to acknowledge problems associated with alcohol – and intolerant of "drugs" – again, reflecting popular perceptions and the populist line taken by some sectors of the media. Many primary care teams think this way or adopt a more judgmental approach, more akin to that towards drugs, where there has never been toleration of misuse amongst doctors. In fact, it is a common route to being struck off the medical register so that, where individual doctors have become dependent, it is a matter of shame and concealment.

These attitudes form the backdrop both to the perception and to the reality of stigmatisation of alcohol and drug misusers. Indeed, people who misuse substances often report such attitudes in their contacts with doctors and others working in primary care.

Two groups believe themselves stigmatised. There are those who wish to continue their habit and resent not receiving prescriptions that will facilitate this. Then there are those who want help in ending their addiction but do not find it. Both groups believe that they do not achieve their ends because of wilful discrimination and stigmatisation.

Substance misusers are not alone in feeling that primary care does not always meet their needs. The various primary care organisations in the NHS, as well as individual practices, always have to make choices about the best use of scarce personal, financial and infrastructural resources. Substance misuse services are not considered to be a high priority and practices may refuse to provide them.

The result is stigmatisation through discrimination, a fine distinction lost on those seeking help. It can result in individuals not being accepted on to practice lists, with a consequent inability to obtain other required care not directly related to substance misuse.

People may feel stigmatised by the diagnostic terms used as professional shorthand on a provisional or definitive basis. The avoidance of labelling individuals with preconceptions requires the members of the primary care team to exercise skill and delicacy in the use of language when communicating advice. Scarcity and under-resourcing of specialised services often mean that it is impossible to find effective care outside the practice, so increasing feelings of stigmatisation.

Surveys have shown that, despite their professional training, some doctors share the stigmatising attitudes of society at large and allow this to carry over into their professional work. Better training and familiarisation with what can be achieved will overcome these attitudes. In 2002, the NHS in England started a considerable investment in training and material resources for the provision of expert drug and alcohol services in primary care.

In time, this investment should lead to adjustment of attitudes, especially those reflecting the view that such problems are thoughtlessly self-inflicted and, as in the days of the Poor Law, not deserving of care. Society has very different attitudes to different types of risky behaviour – for a range of very complex reasons. Perhaps the strongest argument is the case for humane and appropriate treatment for substance misusers..

There are already some practice teams that are able to take on a substantial workload in the field. This requires individual knowledge and enthusiasm, proper training and resources, control of numbers accepted, the use of care and treatment contracts with patients and specialised, secondary backup. Without these, it is easy for services to be overwhelmed by demand, to the detriment of the range of services that the practice must provide.

An important source of stigma and discriminatory attitudes among primary care professionals is bad experiences with a minority of patients.

The numbers resorting to violence are very small, and dwarfed by those who harm themselves, but they are often persistent and repeatedly take up much time, causing disproportionate damage to a practice's professional image and its ability to care properly for its other patients. Sadly, these are the patients that are remembered, rather than those who comply and do well in treatment.

The measures that practices and Primary Care Organisations take with such individuals may be seen as discriminatory. There is often a blanket negative approach, so that others for whom treatment would be positive and rewarding for both patient and professional also find it impossible to gain access to such care.

Achieving change requires social action to reduce the acceptability of substance misuse; professional action to improve early training; attitude consciousness and lifelong support; and resource allocation action to match the demand for care.

### **The work place and drug screening**

As the rate of drug and alcohol misuse rises in the population, so too will those calling for testing for these substances amongst the work force. It is already common in the United States of America: there, over the last 30 years, pre-employment and random drug and alcohol testing has become a multimillion dollar business with an estimated 70% of all US companies testing for drugs.

Even in the United Kingdom, between 200,000–300,000 tests are carried out each year, mainly in occupations that involve security (armed forces, prison service) and transport (rail and underground drivers). This is still significantly lower than the proportion of employees tested in the US.

How is testing carried out?

Drug and alcohol testing can be done by a variety of means, with urine, blood, saliva, breath and hair testing being the most common means. Other approaches include direct questioning or the use of psychological tests, and even eye tests.

Why test?

There are a number of reasons that merit examination. Most drug testing approaches stem from the United States; and hence an understanding of the forces driving such testing need to be looked at in the context of drug misuse and the response to use in America, especially drug misuse in the 1980s and 1990s.

Those who promote testing cite the epidemic of drug misuse and associated high levels of violence and property crime and claim that testing reduces the demand for drugs by acting as a deterrent to those in employment. The concomitant response to drug misuse in the United States (the so-called “War on Drugs”) propagated the idea that work force testing would eliminate the market for drugs. Others supported drug testing after a number of high profile accidents found that drugs and or alcohol were implicated.

From a UK perspective, the best known of these was when the oil tanker Exxon Valdez crashed in 1989. This accident was linked to alcohol use. By testing for drug and alcohol misuse, work place safety would be increased by reducing the number of injuries and accidents from illicit use or inappropriate use of licit substances. The rise of drug testing is also linked to the development of reliable technology for testing and the increasing sophistication of the technology behind testing.

Does drug and alcohol use affect the work force?

There is evidence that alcohol use, and particularly dependence, is associated with decreased productivity, higher rates of absenteeism, lateness and aggression. With regard to illicit drugs, research evidence appears inconclusive, though there are a small number of studies that provide slight evidence of an association between illicit drug use and lowered employee productivity and performance.

Reasons for testing

The commonest argument is that testing reduces employee risk (injury in the work place), employer risk (costs of work force drug and alcohol use in terms of accidents, time off work, productivity and performance), customer risk and risk to society (reduce demand for drugs by increasing risk of sanctions of use even in an employee's own time).

The arguments against testing are that it may contravene employee rights to privacy and, for some, may constitute a humiliating and intrusive procedure, which may lead to legal action if the test is not done according to protocol and policy. False positive results can lead to embarrassment and incorrectly labelling the employee as a drug or alcohol misuser.

Research literature suggests that the effectiveness, efficacy and cost-effectiveness of drug testing programmes have not been empirically supported. Many researchers contend that they remain an expensive way of responding to potential drug and alcohol misuse, and that a more appropriate method of controlling substance misuse in the work place is to improve reference checking, the interview process and the training of supervisors. Employee Assistance Programmes should be established, providing work place counselling and medical services that provide confidential care and health promotion services.

When is testing carried out?

The most common time for testing is pre-employment assessment, with a positive result leading to the individual not being employed. Other testing can be through a variety of means: random, periodic (as part of an annual health check), probable cause testing (post-accident or in those exhibiting signs of intoxication or withdrawal), reasonable suspicion testing (for example, if an employee is absent for long periods of time or shows behavioural signs such as lateness) and post-treatment testing (relapse monitoring).

What is the result of a positive test?

Positive tests in these examples can include dismissal, rehabilitation, treatment or no further action. The sanction chosen may depend on the rationale underpinning the testing policy.

What is the effectiveness of work force testing?

Work force testing may be effective and certainly some research points to testing reducing rates of occupational injury and improving employee performance and productivity. However, there are too few empirical studies on the effectiveness of workforce testing to draw these conclusions with conviction, and most research fails to take account of the possible and actual effect of non-drug testing factors, such as increased employee training and better management.

Positive tests do not establish impairment and merely indicate use at some point in the previous days or weeks. A positive test gives no information on "how I perform at my job now" and may overplay the relevance of "what I did last Saturday night...unrelated to work". This is a main focus of the civil liberty argument.

Whither work place testing?

Work force testing generates more questions than it solves. Amongst these are ethical, social, legal, political, economical and methodological issues. None of these can be answered simply; they require sensible public debate and independent inquiry to evaluate the options and generate a greater degree of consensus on best employer practice.

### **Alcohol, drugs and communicable diseases**

Drug and alcohol misuse is associated with a number of infectious diseases. Primarily, these are the blood-borne viruses that can be transmitted by sharing drug-injecting equipment – HIV, hepatitis C and hepatitis B. There are other infectious diseases to which those who misuse drugs and alcohol may be more susceptible, perhaps because they are homeless or in poor health, but no particular disease carries the level of stigma attached to blood-borne viruses. Substance misusers are perceived generally as being riddled with highly contagious illnesses.

It is commonly believed that most drug users are infected with HIV. In fact, HIV cannot survive for long outside the body and sharing a syringe is a much less effective way of passing it from one person to another than having unprotected sexual intercourse. Consequently, HIV is much less prevalent amongst intravenous drug users than are hepatitis B and hepatitis C. Hepatitis C that is the most usual infectious disease carried by current injecting drug users, with around a third infected.

Drug and alcohol misuse is so stigmatised that the potentially fatal nature of these blood-borne diseases rarely elicits compassion. Instead it adds an extra dimension to the stigma, reinforcing the perception that alcoholics and addicts are 'dirty', that their problems are self-inflicted and, more than that, that they *deserve* to be ill and die, that it is some kind of God-given punishment. What is not generally recognised is that drug and alcohol misusers very often feel the same way about themselves.

Much of the belief that people who misuse drugs and alcohol deserve the unpleasant things that happen to them rests on the idea that they are taking these substances "for fun" and by choice. Regardless of how it started out, by the time they are homeless or injecting themselves, it would be hard to describe their behaviour as "fun". Instead, it is a measure of the power of the compulsion they experience that they are prepared to risk catching life-threatening diseases.

Not everyone, even equipped with all the facts, can be persuaded that much of the stigma around drug and alcohol misusers is undeserved. However, from a purely practical point of view, this stigma has undesirable consequences for society generally. This is especially true in the area of communicable diseases, which are a threat to public health as a whole.

Blood-borne viruses, for example, can be passed from one person to another in many more ways than just sharing a syringe: they can be transmitted by sharing toothbrushes, in some cases by sex and through reusing poorly sterilised dental, medical, tattooing or body-piercing equipment. Preventing their spread requires that carriers are identified, that where possible they are treated and that they are informed of ways to avoid infecting others. All of these are impeded by the effects of stigma.

Since no one wants to admit to having a problem with drugs or alcohol, those that do so find it hard to admit it to themselves and even harder to talk about it to others. This is a barrier to contacting GPs, drug and alcohol teams and others who could give vital information about infectious diseases. Even when they do have the information that they could be at risk, there is understandable reluctance to come forward for testing if a positive result, or even requesting a test, immediately labels them as having a drug or alcohol problem.

Typically, drug and alcohol misusers think about getting tested for these diseases only after they have stopped drinking or taking drugs, hardly the time they want to have something added to their medical records that will stay there forever, surfacing every time they want medical insurance, a mortgage or a new job. This stigma is particularly poignant for people who contracted the disease in some other way, such as a blood transfusion before proper screening was introduced.

Treatment is also affected. The National Institute for Clinical Excellence, which recommends what treatments the NHS should provide and to whom, decided in 2000 that current injecting drug misusers should not be treated for hepatitis C. This was on the grounds that they would not stick to the treatment regime because their lives are too chaotic. Obviously, other people also have chaotic lives but it is the drug misusers who are specifically excluded, even though studies have shown that, properly selected, drug misusers adhere to treatment as well as anyone else. It is amongst current drug misusers that a significant proportion of new infection occurs, and consequently these are vital people to treat in order to eradicate the disease.

Influence on governments is also important. £20 million was spent on the awareness campaign to prevent the spread of HIV, when that was seen as a disease of homosexual men. There were many reasons, including political lobbying by influential groups, at least in the US, where there is substantial anti-discrimination legislation. Compare this to £700,000 over 2 years that has been proposed to alert the public to blood-borne viruses, now that they are perceived as drug-related.

When the stigma of drug and alcohol misuse becomes attached to a certain disease, the consequences are equally unfair for those who contract it in some other way. Those who contracted HIV or hepatitis C through a blood transfusion during the 1980s, before screening was introduced, have a life-threatening illness and are suspected of becoming infected through substance misuse.

The stigma attached to substance misusers who are at risk of blood-borne viruses affects them, their families and society at large, as well as damaging treatment and public health measures to deal with the diseases.

## **Treatment**

How many people have a problem?

Accurate figures of how many people misuse drugs and alcohol in the general population are not known. Estimates are made by looking at pooled data on hospital admissions, accidents and working days lost.

- 20-25% of patients in acute hospital beds have alcohol as a significant contributory factor.
- 20% of fatal accidents at work involve victims above the drink-driving limit.
- 8-14 million working days are lost each year through alcohol-related absenteeism.

1 in 4 men and 1 in 10 women drink over the recommended upper limit for safe drinking. More men than women use opiates. Although many young people try drugs, a smaller number become dependent with a regular drug habit. 7% of the population is alcohol dependent and 2% is drug dependent. These are compelling figures.

What treatments are available?

A person may not be aware that he/she has an escalating problem. Many people seek help because of the consequences of their substance, including adverse effects on physical health, psychological well-being, legal problems, work and home life. Many people may not be ready to consider stopping their drug or alcohol use and may deny the problem.

Education/awareness programmes

It is vital that the population becomes more aware of the dangers of substance misuse. The message on drink-driving has achieved an improvement in behaviour because it has been consistently delivered over 25 years. Similar messages around binge drinking and drug misuse need to be applied. Health professionals can help to identify alcohol and drug misuse as early as possible.

Harm minimisation

If people are not willing to change their substance misuse, health professionals or others may want to discuss the consequences of continued use in order for the individual to weigh up the pros and cons of continued use. Advice on safer injecting, sterile equipment, and the risks of diseases such as hepatitis B, hepatitis C and HIV need to be given.

Help lines

There may be many reasons why people do not approach statutory agencies for treatment or advice. Help lines may be the first port of call. Individuals of all ages can seek confidential help from a variety of sources.

Samaritans 0845 909090

Saneline 01645 678000

National Drugs Helpline 0800 776600 (now called "Frank" <http://www.talktofrank.com>)

NHS Direct 0845-4647

Carers' Line 0808 808 7777

Drugs in school help line 0808 8000 800

And many local help lines.

Self-help/support groups

Alcoholics Anonymous (AA) is a well established self-help group run which has been in existence worldwide for many years. It has a network of meetings accessible to all.

AA 0345 697555

Many other self help/support groups exist. Many are run by ex-users, eg

Narcotics Anonymous 020 7730 0009

Al Anon- for family and friends of people with alcohol problems 020 7403 0888

Families Anonymous

Al-Ateen

Cocaine Anonymous.

Non-statutory agencies/street agencies/walk-in centres

Most larger towns have non-statutory drug and alcohol agencies. These have experienced staff able to answer queries/questions and give advice around drug and alcohol issues. They may offer counselling, youth groups and other selected groups as well as alternative therapies including aromatherapy and acupuncture. People are able to access these services anonymously and without their own GP being informed.

#### GP/health centre

Ideally, primary health care professionals are best placed to identify a substance use problem. People wanting to try to stop or reduce their substance misuse often approach their GP either for the problem itself or a related issue. An assessment will be made in order to understand the extent of a person's alcohol or drug use and its effect on his/her life and whether the person is physically dependent on the substance. This may involve blood and urine tests.

If the person is felt to be dependent on a substance where there is a physical withdrawal syndrome, a detoxification regime may be prescribed by the GP. This is a reducing course of another drug to relieve unpleasant and potentially dangerous withdrawal symptoms. It may be that the person is referred to a specialist drug and alcohol team/unit, but this will depend on the history and the severity of the problems.

Admission to hospital for further assessment and treatment is sometimes necessary because of the complexity and risk posed by the problems. In the longer term people need to learn about the ways of living without using substances. Talking therapies can help. The GP may refer to other agencies for further psychological interventions or to a specialist community drug and alcohol team, if appropriate.

#### Community drug and alcohol teams

These are multidisciplinary teams offering a variety of treatment options. These will include assessment, detoxification programmes, maintenance programmes, individual therapy, specialist groups, alternative therapies as well as inpatient treatments. Referrals are made to these teams from many sources including health professionals, non-statutory agencies, probation, social services and, in many areas, people who feel they would like help can refer themselves.

#### Rehabilitation programmes

People who have had a drug and/or alcohol problem for a long time may need to join a residential rehabilitation programme. Many of these are run by non-statutory agencies and may be staffed by ex-users. There are many longer-term rehabilitation programmes involving half-way houses that can be private or social services funded.

#### Does treatment work?

There is a wealth of evidence that treatments for drug and alcohol misusers are effective at reducing the harm they suffer and the risks they present to themselves and other people. People in opiate treatment programmes show a large reduction in illicit drug misuse, in criminal activity and in the risk of contracting and transmitting blood-borne viruses. Modest and more extensive interventions reduce the chance of relapse in those with alcohol dependence.

Two things are clear: social support (housing, employment, education and training) and treatment agencies have to collaborate effectively and recognise that treatment goals have to be realistic; and resources are scarce and must be augmented at all levels to provide a spectrum of care to meet the diverse and changing needs of people who misuse substances.

The negative image of these people and the nihilistic image of treatment are serious barriers to improving the public health and well-being of the nation. Selective use of criminal justice measures may be beneficial in a range of behavioural problems, including substance misuse. Sometimes, the problems are so entrenched that it takes powerful external motivating factors to initiate the journey to recovery.

### **Medical education**

Every hospital department is affected by substance misusers. Resources are scarce but, though comprehensive figures are not available, it is estimated that the NHS spends £1.4 billion on drug-related problems and £2 billion on alcohol-related problems each year. Each person with alcohol misuse costs health services about 2-3 times more than someone without this problem. The average cost of treatment for

substance misusers in the UK is about £2,000 per annum for inpatient treatment and £400 per annum for outpatient treatment.

The costs to industry of excessive alcohol consumption are estimated at over £2 billion per year, as a result of unemployment, premature death and sickness absence. The estimated UK taxation revenue from alcohol is over £10 billion per annum.

The consequences of smoking cost the NHS approximately £1.5 billion per year. For a typical primary care trust this means £14 million per year, broken down as GP consultations (£2.5m), prescriptions (£1.5m), inpatient hospital stays (£3.2m), day care (£1.9m) and outpatient consultations (£4.9m). The estimated UK taxation revenue from tobacco is about £7.5 billion per annum.

For both alcohol and tobacco, price is the most effective way of reducing overall consumption. The US experience of alcohol prohibition indicates that it does not work.

Treatment is cost-effective, with studies showing that the treatment of opiate users saves much more money than it costs. North American studies estimate that for every \$10,000 invested in alcohol treatment, \$30,000 is saved by the managed care provider because other, more expensive, treatment is not needed. There is compelling evidence that a large proportion of these interventions can be delivered by generally trained doctors (ie those not specialising in substance misuse) and by other health care professionals.

The high prevalence figures, the costs and our national strategy, all support the involvement of doctors at all levels and in all clinical specialities in the screening of, brief intervention in, and referral of patients with a substance misuse factor in their illnesses. Medical students are also young people who are as likely to be involved in substance misuse as the general population. Thus, it is important for both their personal and professional development that substance misuse is adequately covered in the curriculum. This can happen only with sufficient training, commensurate with the prevalence of the problem, and which is initiated at undergraduate level.

An additional dimension is the extent of substance misuse amongst doctors. Appraisal, revalidation and performance management are all affected by the health of the work force. Without specific attention, medical schools may have a perverse effect on doctors' own behaviour and health because of their "culture", especially regarding alcohol. Postgraduate training is also crucial for all specialities.

The Royal College of General Practitioners has been funded by the Department of Health in England to provide postgraduate, certificate level training in drug misuse which provides 30 hours training. There are 400 GPs in the first cohort. On the basis of the experience of one medical school, it is recommended that about 60 hours of training covers the fundamental knowledge and skills in substance misuse required of the newly qualified doctor.

Therefore, medical education must achieve the objective of training doctors to respond appropriately in terms of offering comprehensive assessment and implementing effective interventions. Both professional and patient experience indicate that most doctors do not achieve this objective. Medical education requires change, especially in promoting greater self-awareness, attitudinal change, acquisition of the requisite knowledge, and the development the necessary skills.

As mentioned above, there are excellent training opportunities in some UK medical schools. Some overseas medical schools also require all aspects of the medical undergraduate course to include content relating to drug and alcohol misuse.

It is clear that unless medical training addresses the attitudes that underpin the stigmatisation of substance misusing patients, and supports the acquisition of the necessary skills and knowledge, a significant proportion of patients will be denied due response and intervention.

## **Conclusion**

There is a clear case that it is the *behaviour* (drug and alcohol misuse) that should be stigmatised, not the *individual*. There are clear synergies between providing effective treatment and improving public health and community safety.

Substance misuse is a powerful influence and is itself affected by external factors beyond the control of an individual. People have responsibilities to seek help as well as rights to receive it. Reducing stigma will encourage the former and facilitate the latter.

The Changing Minds Campaign has striven to inform and educate the general public. Now medical and other health care professionals must be offered education and training to engender the right professional attitudes and behaviours to meet these public expectations.

**Written by the Alcohol and Drugs Misuse Subgroup of the Changing Minds Campaign**

September 2003